Sample Declaration of Health Care Coverage Employee Form

This form is only to be used for employees of an employer who has offered to pay some portion of a health care plan, for which the employee has opted not to accept.

Enrollment Year _____
(Retain this record for 4 years)

The purpose of this form is to gather information regarding health care coverage. This information will be used **solely** for the purposes of determining if Employer Health Care Contributions are due by your employer, as required by Act 191 of 2006, An Act Relating to Health Care Affordability for Vermonters.

Print Full Name: _____

Employee or Social Security Number: _____

☐ I do have health care coverage.

NOTE: For purposes of this form, health care coverage includes: Catamount Health Plan, Medicare, Medicaid, the Vermont Health Access Plan (VHAP), or Dr. Dynasaur or a private or employer-sponsored insurance plan that includes both hospital and physician services.

☐ I do not have health care coverage.

NOTE: If at some point health care coverage is obtained, you are encouraged to let your employer know.

By signature below, I certify the information contained in this form is the truth.

_____ _____
Employee's Signature Date

HC-2 (1/07)